APPENDIX E
MODIFIERS THAT AFFECT PAYMENT

Only modifiers that affect payment are listed in this section. Refer to current CPT® and HCPCS books for complete modifier descriptions and instructions.

CPT® MODIFIERS

-22 Unusual services
Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

-24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period
Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

-25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure
Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less. Refer to the Professional Services section for information on the use of modifier –25.

-26 Professional component
Certain procedures are a combination of the professional (-26) and technical (-TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the -26 nor the -TC modifier should be used.

-50 Bilateral surgery
The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must bill using two line items on the bill form. The modifier -50 should be applied to the second line item.

-51 Multiple surgery
For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

-52 Reduced services
Payment is made at the fee schedule level or billed charge, whichever is less.

-53 Discontinued services
CMS has established reduced RVUs for CPT® code 45378 when billed with modifier -53. The department prices this code-modifier combination according to those RVUs.

-54 Surgical care only *
When one physician performs a surgical procedure and another provides preoperative and/or postoperative management

-55 Postoperative management only *

When one physician performs the postoperative management and another physician has performed the surgical procedure.

-56 Preoperative management only *
When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.

* **When providing less than the global surgical package providers should use modifiers -54, -55, and -56.** These modifiers are designed to ensure that the sum of all allowances for all providers does not exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider of each portion of the global surgery services.

-57 Decision for surgery
Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow-up period. It should not be used with visits furnished during the global period of minor procedures (0-10 day global period) unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

-60 Altered Surgical Field
Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

-62 Two surgeons
For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an assistant-at-surgery in these cases.

-66 Team surgery
Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Supporting documentation is required for this review.

-78 Return to the operating room for a related procedure during the postoperative period
Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

-79 Unrelated procedure or service by the same physician during the postoperative period
Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

-80 Assistant surgeon *

-81 Minimum assistant surgeon *

-82 Assistant surgeon (when qualified resident surgeon not available) *

* **Assistant Surgeon Modifiers**. Physicians who assist the primary physician in surgery should use modifiers -80, -81 or -82 depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty percent of the global surgery amount for the procedure, whichever is less. Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable.

-91 Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test values(s) (separate specimens taken in separate encounters)
Payment will be made for repeat test(s) performed for the same patient on the same day when specimen(s) have been taken from separate encounters. Test(s) normally performed as a series, e.g. glucose tolerance test do not qualify as separate encounters. The medical necessity for repeating the test(s) must be documented in the patient record.

-99 Multiple modifiers
This modifier should only be used when two or more modifiers affect payment.
Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only modifier -99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.

HCPCS MODIFIERS

-GT Teleconsultations via interactive audio and video telecommunication systems
Payment policies for teleconsultations are located in the Professional Services section.

-LT Left side
Although this modifier does not affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

-RT Right side
Although this modifier does not affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

-SG Ambulatory surgical center (ASC) facility service
Bill the appropriate CPT® surgical code(s) adding this modifier -SG to each surgery code.

-TC Technical component
Certain procedures are a combination of the professional (-26) and technical (-TC) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the -26 nor -TC modifier should be used. Refer to the CPT® modifier section for the use of the -26 modifier.

LOCAL MODIFIER

-1S Surgical dressings for home use
Bill the appropriate HCPCS code for each dressing item using this modifier -1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.